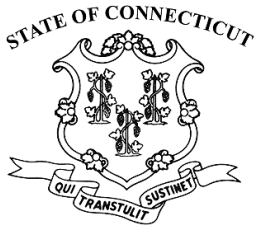

House Bill No. 7190

Public Act No. 17-135

AN ACT CONCERNING MEDICAID PROVIDER AUDITS AND ELECTRONIC VISIT VERIFICATION.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Subsection (d) of section 17b-99 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(d) (1) The Commissioner of Social Services, or any entity with which the commissioner contracts for the purpose of conducting an audit of a service provider that participates as a provider of services in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall conduct any such audit in accordance with the provisions of this subsection. For purposes of this subsection, (A) "clerical error" means an unintentional typographical, scrivener's or computer error, (B) "extrapolation" means the determination of an unknown value by projecting the results of the review of a sample to the universe from which the sample was drawn, (C) "ninety-five per cent confidence level" means there is a probability of at least ninety-five per cent that the result is reliable, (D) "provider" means a person, public agency, private agency or proprietary agency that is licensed, certified or

otherwise approved by the commissioner to supply services authorized by the programs set forth in said chapters, (E) "stratified sampling" means a method of sampling that involves the division of a population into smaller groups known as strata based on shared attributes, characteristics or similar paid claim amounts, (F) "statistically valid sampling and extrapolation methodology" means a methodology that is (i) validated by a statistician who has completed graduate work in statistics and has significant experience developing statistically valid samples and extrapolating the results of such samples on behalf of government entities, (ii) provides for the exclusion of highly unusual claims that are not representative of the universe of paid claims, (iii) has a ninety-five per cent confidence level or greater, and (iv) includes stratified sampling when applicable, and (G) "universe" means a defined population of claims submitted by a provider during a specific time period.

(2) Not less than thirty days prior to the commencement of any such audit, the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider, shall provide written notification of the audit to such provider and the statistically valid sampling and extrapolation methodology to be used in conducting such audit, unless the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider makes a good faith determination that (A) the health or safety of a recipient of services is at risk; or (B) the provider is engaging in vendor fraud. At the commencement of the audit, the commissioner, or any entity with which the commissioner contracts to conduct an audit of a participating provider, shall disclose (i) the name and contact information of the assigned auditor or auditors, (ii) the audit location, including notice of whether such audit shall be conducted on-site or through record submission, and (iii) the manner by which information requested shall be submitted. No audit shall include claims paid more than thirty-six months from the date claims

are selected for the audit. **[**A**]** The commissioner shall not apply an agency policy, guideline, bulletin or manual provision or other criteria to make determinations in an audit unless the policy, guideline, bulletin or manual provision or other criteria, together with the effective date, was promulgated and distributed to a provider prior to provision of a service included in a claim being audited. The commissioner shall accept a scanned copy of documentation supporting a claim **[**shall be acceptable**]** when the original documentation is unavailable.

(3) Any clerical error discovered in a record or document produced for any such audit shall not of itself constitute a wilful violation of program rules unless proof of intent to commit fraud or otherwise violate program rules is established. In determining which providers shall be subject to audits, the Commissioner of Social Services may give consideration to the history of a provider's compliance in addition to other criteria used to select a provider for an audit.

(4) A finding of overpayment or underpayment to a provider in a program operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a provider for which rates are established pursuant to section 17b-340, shall not be based on extrapolation unless the total net amount of extrapolated overpayment calculated from a statistically valid sampling and extrapolation methodology exceeds one and three-quarters per cent of total claims paid to the provider for the audit period.

(5) A provider, in complying with the requirements of any such audit, shall be allowed not less than thirty days to provide documentation in connection with any discrepancy discovered and brought to the attention of such provider in the course of any such audit. Such documentation may include evidence that errors concerning payment and billing resulted from a provider's transition to a new payment or billing service or accounting system. The

commissioner shall not calculate an overpayment based on extrapolation or attempt to recover such extrapolated overpayment when the provider presents credible evidence that an error by the commissioner, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, caused the overpayment, provided the commissioner may recover the amount of the original overpayment.

(6) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a provider of any of the programs operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall produce a preliminary written report concerning any audit conducted pursuant to this subsection, and such preliminary report shall be provided to the provider that was the subject of the audit not later than sixty days after the conclusion of such audit.

(7) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a provider of any of the programs operated or administered by the department pursuant to this chapter or chapter 319t, 319v, 319y or 319ff, except a service provider for which rates are established pursuant to section 17b-340, shall, following the issuance of the preliminary report pursuant to subdivision (6) of this subsection, hold an exit conference with any provider that was the subject of any audit pursuant to this subsection for the purpose of discussing the preliminary report. Such provider may present evidence at such exit conference refuting findings in the preliminary report.

(8) The commissioner, or any entity with which the commissioner contracts, for the purpose of conducting an audit of a service provider, shall produce a final written report concerning any audit conducted pursuant to this subsection. Such final written report shall be provided

to the provider that was the subject of the audit not later than sixty days after the date of the exit conference conducted pursuant to subdivision (7) of this subsection, unless the commissioner, or any entity with which the commissioner contracts for the purpose of conducting an audit of a service provider, agrees to a later date or there are other referrals or investigations pending concerning the provider.

(9) Any provider aggrieved by a decision contained in a final written report issued pursuant to subdivision (8) of this subsection may, not later than thirty days after the receipt of the final report, request, in writing, a contested case hearing in accordance with chapter 54. Such request shall contain a detailed written description of each specific item of aggrievement. The designee of the commissioner who presides over the hearing shall be impartial and shall not be an employee of the Department of Social Services Office of Quality Assurance or an employee of an entity with which the commissioner contracts for the purpose of conducting an audit of a service provider. A provider shall be permitted to raise during such hearing that a negative audit finding was due to a provider's compliance with a state or federal law or regulation. Following review on all items of aggrievement, the designee of the commissioner who presides over the hearing shall issue a final decision not later than ninety days following the close of evidence or the date on which final briefs are filed, whichever occurs later. When a provider requests a hearing pursuant to this subdivision, and the provider is contesting an overpayment amount based on extrapolation, the Department of Social Services shall not recoup the overpayment amount at issue until a final decision is issued after the hearing.

(10) The provisions of this subsection shall not apply to any audit conducted by the Medicaid Fraud Control Unit established within the Office of the Chief State's Attorney.

(11) The commissioner shall provide free training to providers on how to enter claims to avoid errors and shall post information on the department's Internet web site concerning the auditing process and methods to avoid clerical errors. **[**Not later than February 1, 2015, the**]** The commissioner shall establish and publish on the department's Internet web site audit protocols to assist the Medicaid provider community in developing programs to improve compliance with Medicaid requirements under state and federal laws and regulations, provided audit protocols may not be relied upon to create a substantive or procedural right or benefit enforceable at law or in equity by any person, including a corporation. The commissioner shall establish audit protocols for specific providers or categories of service, including, but not limited to: (A) Licensed home health agencies, (B) drug and alcohol treatment centers, (C) durable medical equipment, (D) hospital outpatient services, (E) physician and nursing services, (F) dental services, (G) behavioral health services, (H) pharmaceutical services, (I) emergency and nonemergency medical transportation services, and (J) **[**not later than January 1, 2016,**]** homemaker companion services. The commissioner shall ensure that the Department of Social Services, or any entity with which the commissioner contracts to conduct an audit pursuant to this subsection, has on staff or consults with, as needed, a medical or dental professional who is experienced in the treatment, billing and coding procedures used by the provider being audited.

Sec. 2. (*Effective from passage*) (a) For purposes of this section, (1) "electronic visit verification" means the system required pursuant to the 21st Century Cures Act, P.L. 114-255, that verifies the date, time and site of a provider visit and services offered to a client in a home and community-based service program administered by the Department of Social Services and funded under Medicaid, (2) "nonmedical provider" means a Medicaid-enrolled provider of home care who is not licensed by the Department of Public Health, and (3) "medical home health care

provider" means a Medicaid-enrolled provider licensed by the Department of Public Health with Medicare certification to provide medically skilled home health care services under the supervision of a registered nurse.

(b) Notwithstanding the provisions of section 17b-99 of the general statutes, as amended by this act, the Commissioner of Social Services shall not extrapolate any overpayments due to errors related to implementation of a state-required electronic visit verification system by (1) a nonmedical home care provider from January 1, 2017, to May 1, 2017, inclusive, and (2) a medical home health care provider from April 1, 2017, to August 1, 2017, inclusive.

(c) The Commissioner of Social Services shall submit a report, in accordance with the provisions of section 11-4a of the general statutes, to the joint standing committee of the General Assembly having cognizance of matters relating to human services on the implementation of the state-required electronic visit verification system not later than July 1, 2018. Such report shall include (1) any problems experienced in implementation of the system, (2) recommendations to resolve identified problems, and (3) cost savings identified as a result of the system.

Approved June 27, 2017